APPLICATION FOR A DISABLED HUNTER PERMIT

FOR OFFICE USE ONLY
PERMIT # :
DATE ISSUED:
ISSUED BY:

PLEASE PRINT

NAME_____
LAST FIRST M.I.

MAILING ADDRESS_____

CITY_____STATE_____ZIP_____ DATE OF BIRTH_____

SOCIAL SECURITY # (Required) XXX-XX-_____ TELEPHONE NUMBER_____

SEX_____ WEIGHT_____ HEIGHT_____ EYE COLOR_____ HAIR COLOR_____

I hereby swear, under penalty of prosecution, I am permanently disabled as described in this application.

SIGNATURE_____ DATE_____

IF APPLICANT IS APPLYING AS A DISABLED VETERAN, APPLICANT MUST COMPLETE:

☐ Has written proof that the last official certification of record by the United States Department of Veteran Affairs or any branch of the Armed Forces of the United States shows the person to be at least sixty-five (65) percent physically disabled.

IF APPLICANT IS NOT APPLYING AS A DISABLED VETERAN, PHYSICIAN MUST COMPLETE:

I, the undersigned, swear that I am a licensed physician, optometrist or ophthalmologist and find the above named applicant to be disabled as defined by one or more of the following condition(s):
PLEASE CHECK THE APPROPRIATE BOX(ES):

☐ Is permanently unable to walk without the use of, or assistance from, a wheelchair, scooter, or walker;

☐ Is restricted by lung disease to the extent the person's forced expiratory volume for one (1) second, when measured by a spirometer, is less than thirty-five (35) percent predicted, or arterial oxygen tension is less than fifty-five (55) mm/Hg on room air at rest;

☐ Has a cardiac condition to the extent the person's functional limitations are classified in severity as Class III or Class IV, according to standards established by the American Heart Association;

☐ Has a permanent, physical impairment that prevents the person from holding or shooting a firearm or bow in hand;

☐ Has central visual acuity that permanently does not exceed 20/200 in the better eye with corrective lenses, or the widest diameter of the visual field is not greater than twenty (20) degrees.

NAME_____
LICENSED PHYSICIAN, OPTOMETRIST, OR OPHTHALMOLOGIST (**PLEASE PRINT**)

ADDRESS_____

CITY_____ STATE_____ ZIP_____ Telephone_____

_____ _____
Signature of Licensed Physician, Optometrist, or Ophthalmologist Date

Permits are issued only at Wyoming Game and Fish Department Regional Offices located in JACKSON, PINEDALE, CODY, SHERIDAN, GREEN RIVER, LARAMIE, LANDER or CASPER. Applications can be mailed to the headquarters office: License Sales and Accounting, Wyoming Game and Fish Department, 5400 Bishop Boulevard, Cheyenne WY 82006-0001.